Columbia Basin Hematology & Oncology

by Deberie Connor, RN, BSN, OCN, MBA

Columbia Basin Hematology & Oncology, PLLC, is an independent practice composed of 5 medical oncologists, 4 nurse practitioners, and 9 oncology RNs. The practice sees patients with all types of cancer as well as with malignant and benign hematologic conditions. The practice saw close to 1,000 new patients in 2009 and nearly the same in 2010. Patients travel up to two and a half hours to receive services, and come from a wide geographic region that includes parts of Oregon, Washington, and Idaho. Columbia Basin Hematology & Oncology (CBHO) works with three hospitals in the Tri-Cities area:

- Kadlec Regional Medical Center, Richland, Wash.
- Kennewick General Hospital, Kennewick, Wash.
- Lourdes Medical Center, Pasco, Wash.

Overall Transition Policy and Activities

Since CBHO patients who require hospitalization use all of the hospitals in the region, the design of a comprehensive transition policy became a major priority. This task was particularly challenging since each hospital operates on a different model. Kadlec Regional Medical Center is a not-for-profit community hospital with a staff of hospitalists who admit patients for all primary care physicians and most of the subspecialists in the community. Kennewick General Hospital is a public facility with some full-time hospitalists and some practicing primary care physicians who serve as hospitalists on a part-time basis. Lourdes Medical Center is a critical access facility and uses a hospitalist model that is similar to the one used by Kennewick General Hospital.

About three years ago it became evident that patient safety and continuity of care required a uniform policy for patient transitions. CBHO providers met with staff at each of the three hospitals to develop such a policy, and since then there have been regularly scheduled meetings to monitor success and make changes as necessary. The policy, (see page 23) in place since 2007, outlines the process of transition from:

- CBHO to a hospital's inpatient service
- CBHO to an Emergency Department
- CBHO to a hospital's outpatient facility for chemotherapy or transfusion
- From any of the three hospitals to CBHO.

The process begins with a checklist filled out by the admitting oncologist and given to his or her medical assistant. This key document contains the patient's demographic information, as well as the patient's diagnosis, acuity, and reason for admission. The medical assistant calls the hospital to request a bed and faxes the admission orders and recent clinic notes to the admitting hospital. If the oncologist is admitting the patient to his or her own service, the process is complete at this point. In cases where the patient will be admitted to a hospitalist (with the attending oncologist acting as consultant), the policy requires direct provider-to-provider communication by telephone. In situations where the transition of care is more complex, such as a transfer of a patient to an academic medical center, then a more complete set of records is prepared by personnel in the medical records department.

Columbia Basin Hematology & Oncology employs what it terms a "triage nurse" who oversees the clinical elements of the care transition process. (See Figure 1, page 21.) This oncology-certified RN examines the patient record, physician orders, and medication list to ensure correctness and completeness before the information is transmitted to the admitting hospital. The triage nurse navigator uses a telephone triage checklist for admitting patients to a hospital. The checklist uses the acronym SBAR to cover pertinent information for the handoff from practice nurse to hospital nursing unit:

- **S**—Subjective Information
- **B**—Brief Description
- **A**—Assessment
- **R**—Recommendations.

The transition of care checklist is also used for common treatment handoffs, such as chemotherapy treatments, that will be administered at another facility. (See page 22 for the SBAR checklist, Figure 2, and the chemo order checklist, Figure 3.)

Key Team Members

A CBHO designated nurse practitioner makes daily rounds on Columbia Basin Hematology & Oncology patients in the hospitals where the CBHO oncologists see patients. The nurse practitioner reports directly to the physician whose patient is being seen.

When a patient is ready for discharge, the nurse practitioner calls the CBHO scheduler, who collects pertinent patient information over the telephone to begin the reverse transition process from the hospital back to the medical practice—demographic data, diagnosis, date and time of discharge, and the urgency with which the patient will have to be seen by the practice. Within 24 hours of discharge, physician orders, medication lists, and other patient records are transmitted by fax, or in the case of Kadlec Regional Medical Center, these are also available via a Physician Por-

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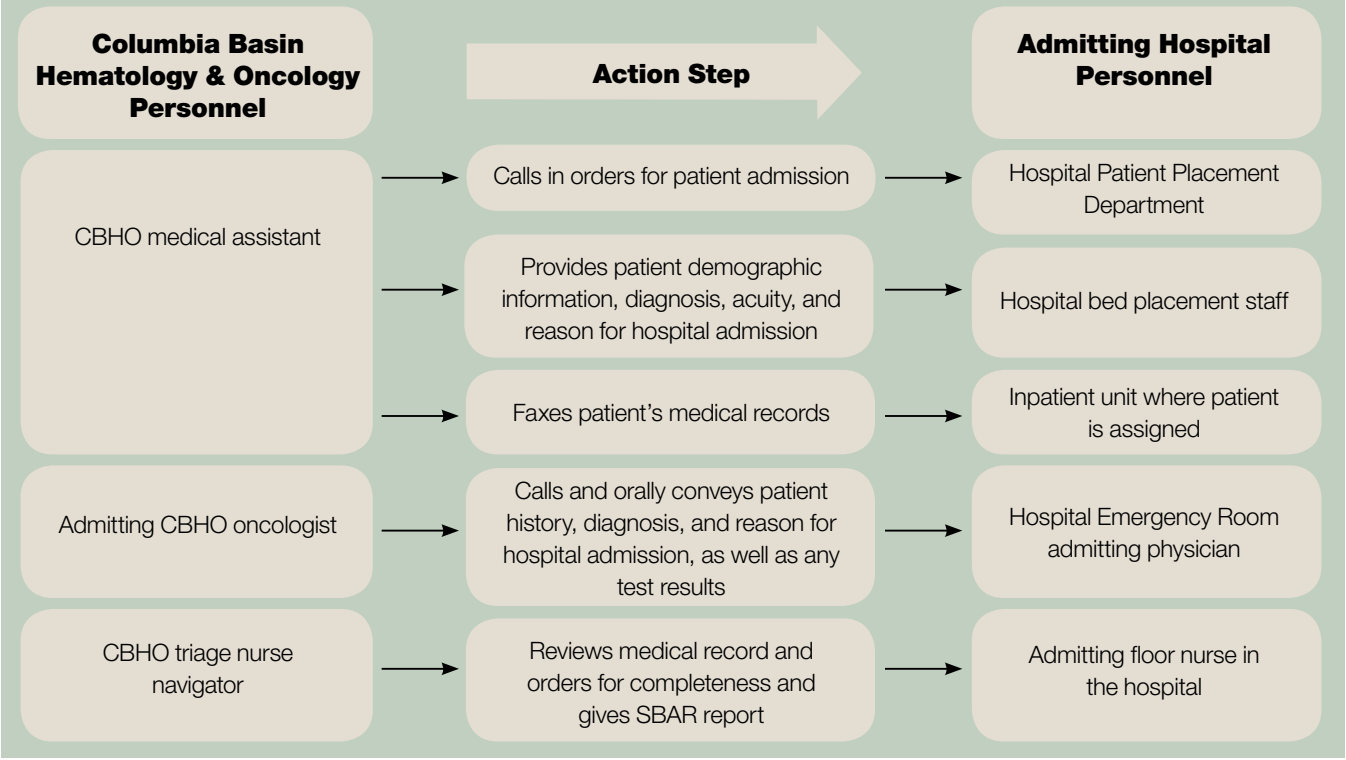
Figure 1. Columbia Basin Hematology & Oncology Patient Transition Process



tal, to the practice, so all the records are available to CBHO providers before the patient arrives for his or her first post-discharge appointment.

As the day of the appointment approaches, a series of standardized steps are carried out. The patient's schedule is given to the medical assistants whose task is to ensure that the hospital's records are electronically available to the provider who will see the patient. The details of the appointment also flow to the front desk staff as they take the responsibility for making the reminder call on the day before the appointment.

Critical Transition Steps

The key to CBHO's transition process is the designation of specific staff to fulfill specific roles. For example, in the transition from inpatient to outpatient care, the nurse practitioner is responsible for alerting appropriate CBHO staff. She communicates complex medical and psychosocial data to the patient's oncologist as a formal "handoff," and transmits the operational information to a specific scheduler in the practice. The scheduler is designated to act on this information and begin the records-gathering process.

Communication between organizations is a vital element in managing transitions across multiple sites. A physician provider from CBHO meets monthly with the staff from each of the three hospitals to discuss patient flow, issues and review what is—and is not—working. In addition, the CBHO nurse manager meets with a peer hospital nurse manager to consider issues involving the day-to-day care of oncology patients.

Medication reconciliation is critical. The Joint Commission's standards require hospitals to provide medication lists to patients at discharge. Although many cancer patients bring these lists with them to their first appointment at CBHO, the data-gathering process provides an independent check on the quality of the information on the patient's list. CBHO asks patients to bring their current medications with them, assuring a complete record that includes both past and current medications.

CBHO uses an electronic health record (EHR) by Rabbit Healthcare Systems. It is a certified and fully integrated system, which is designed specifically for oncology group practices. The practice is currently testing an interface that will allow Rabbit to communicate directly with all three hospital EHRs through Surescripts network, as well as with other agencies that are involved in the care of their patients. One helpful feature in this process is that Rabbit's medication reconciliation uses color coding to distinguish drugs managed or prescribed by a CBHO provider from those written by providers elsewhere. The name of each medication, the amount prescribed, the number of refills, and the reason for prescribing are also part of the record. Chemotherapy drugs are included as part of the overall medication record, easing the process of checking orders for completeness by putting all the information in one place. The Rabbit EHR also provides the ability to generate a Continuity of Care Record (CCR) containing the active patient list, medication list, and most recent diagnostic orders and results in both a readable report and/or xml data format for electronic exchange to the patient's PHR or Care Partners Clinical System. Remember that successful transition of care depends on good communication, whether it is done by phone or via the EMR system.

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Figure 2. Columbia Basin Hematology & Oncology Telephone Triage Documentation Form

Date: _____ Time: _____

Patient Name: _____ MD: _____

Call taken by: _____

Situation (Reason for call; in patient's own words) _____

_____

Background (Problem) _____

_____

Assessment _____

_____

_____

Recommendation (Intervention) _____

_____

_____

Medication/Prescription given: _____

_____

Labs drawn: _____

_____

Physician consulted: _____

Patient/Caller verbalizes understanding of plan/instructions given ☐ Yes ☐ No

Patient/Caller instructed to call if symptoms continue, worsen, or changed ☐ Yes ☐ No

Signature: _____ Length of call (minutes): _____

Figure 3. Columbia Basin Hematology & Oncology Chemotherapy Order Check-off List

1. Print the "right" order for the patient
2. Order must have:
   a. Height
   b. Weight
   c. Allergies
   d. Diagnosis/ICD-9 Code
   e. BSA
3. Order has "right" number of pages
   a. Appointment made?
4. Have labs been drawn?
   a. If no, appointment made
   b. If yes, report attached
5. Authorization for treatment obtained
6. Triage nurse to review the order
7. Physician/nurse practitioner to sign order
8. Any concerns nurses need to know?

Medical Assistant Initial: _____
Date and Time: _____

Triage Nurse Initial: _____
Date and Time: _____

Faxed by: _____
Orders faxed (Date and Time): _____

Columbia Basin Hematology & Oncology, PLLC, Transition of Care Policy

Standard of Practice No. _____

Revised _____

Date _____

Title: Transition of Care

Approved by:

MD _____ **Date**: _____

MD _____ **Date**: _____

MD _____ **Date**: _____

Clinical Manager_____ **Date**: _____

Purpose: To provide guidelines on the care of patients as they transition 1) from the clinic to the hospital, 2) to the clinic after discharged from the hospital, and 3) to off-site chemotherapy treatment.

Procedure:

Transition from Clinic to Hospital

1. The decision is made for the patient to be admitted to the hospital after visit with the physician and nurse practitioner.
2. Patient is evaluated by physician and nurse practitioner for decision on the levels of care needed:
   a. Emergency transport by ambulance to the emergency room
   b. Direct admit to an oncologist
   c. Direct admit to a hospitalist

   For facilities that our physicians do not have admitting privileges, then only option "a" or "c" is used.
3. Medical assistant notifies Patient Placement in the hospital or patient's order for admission.
4. Information such as patient's name, date of birth, diagnosis, reason for admission, date of admission, and acuity of care needed (i.e., ICU, intermediate care, or inpatient oncology unit) is provided to be placement staff.
5. Patient placement calls back with the availability of bed, room number, and what unit the patient is going to be admitted to.
6. Physician speaks to the ER admitting physician of the patient's history, diagnosis, and reason for admission. Tests done (labs drawn, diagnostic results) are also reported to the admitting physician.
7. Current medical records are faxed to the hospital.
8. Using the SBAR, the nurse gives report to the receiving nurse in the hospital (see page 22).
9. Depending on patient's status, an ambulance, or medical transport is called to transfer patient to the hospital.

Off-site Chemotherapy

1. Some patients received their chemotherapy treatment in another facility due to insurance requirements, regimen length, or patient preference.
2. Physician and nurse practitioner notifies medical assistant of the treatment plan.
3. Physician and nurse practitioner writes the chemotherapy order.
4. Using the Chemo Order Check-off List form (see page 22), the steps are followed to ensure completion of orders.
5. Orders are faxed to the outpatient clinic and pharmacy.

Transition from Hospital to the Clinic

1. A designated nurse practitioner makes rounds on patients admitted to the hospital.
2. When a decision is made that the patient will be discharged, then nurse practitioner calls the scheduler in the clinic.
3. Information such as patient's name, DOB, diagnosis, reason for follow-up, and date of follow-up needed is given to the scheduler. The information includes any blood work or diagnostic tests needed prior to appointment schedule.
4. Scheduler makes the appointment; nurse practitioner is made aware of the scheduled appointment.
5. Medical record staff obtains the hospital records.
6. Medical assistant ensures that hospital records and lab draws are ordered and results available for the appointment.
7. On the day before the scheduled appointment, the scheduler makes a reminder call to the patient.

References

McGaw J, et al. A multidisciplinary approach to transition care. *The Permanente Journal*. 2007;11(4):4-9. Available online at: *http://xnet.kp.org/permanentejournal/Fall07/transition_care.pdf*.

Coleman E, Fox P. *Managing Patient Care Transition: A Report of the HMO Care Management Group*. American Health Insurance Plans. Available online at: *http://www.ahip.org*.